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In The
Supreme Court of the United States

JOHN ASHCROFT,
ATTORNEY GENERAL, *ET AL.*,

Petitioner,

v.

ANGEL McCLARY RAICH, *ET AL.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF THE NATIONAL ORGANIZATION FOR THE REFORM OF MARIJUANA LAWS (NORML), THE NORML FOUNDATION, THE NATIONAL ASSOCIATION OF CRIMINAL DEFENSE LAWYERS (NACDL), WASHINGTON ASSOCIATION OF CRIMINAL DEFENSE LAWYERS (WACDL), AND OREGON CRIMINAL DEFENSE LAWYERS ASSOCIATION (OCDLA) AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI*[1]

The National Organization for the Reform of Marijuana Laws (NORML) was organized in 1970, and participates in the public policy debate over marijuana policy for the tens of millions of adult Americans who use marijuana responsibly. NORML lobbies for the rights of responsible marijuana users and other taxpayers and voters who oppose current prohibition policies. NORML has more than 5,000 financial supporters in every state. It also has a grassroots political network of more than 18,000 volunteer activists, including 60 state and local affiliated organizations, who oppose the criminal prohibition of marijuana. The NORML Foundation raises and spends money for work and advocacy in the area of marijuana law reform.

NORML has long supported policies and legislation that would permit seriously ill patients to use cannabis as a medicine when recommended by their physician. NORML opposes the use of marijuana by children and adolescents, and it has published a set of guidelines for responsible marijuana smoking entitled "Principles of Responsible Cannabis Use."

NORML first asserted the medical use of cannabis in 1972 in an administrative petition asking the federal government to move cannabis from schedule I to schedule II of the Controlled Substances Act so doctors could prescribe it. After two years of administrative hearings, in 1988 a DEA Administrative Law Judge (a retired federal judge) found: "Marijuana has been accepted as capable of relieving distress of great numbers of very ill people, and doing so with safety under medical supervision. It would be unreasonable, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefits of this

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[1] Pursuant to S.Ct. Rule 37.6, counsel certifies that no counsel for a party authored any part of this brief. No person or entity other than *amici* made a monetary contribution to the preparation or submission of the brief.

Pursuant to S.Ct. Rule 29.6, NORML, the NORML Foundation, and NACDL are nonprofit corporations. They have no parent corporation, they are not publicly held, nor does a publicly held company own 10% or more of their stock. They are 501(c) (3 & 4) nonprofits.

substance in light of the evidence in this record."[2] The ALJ there recommended "that the Administrator transfer marijuana from Schedule I to Schedule II, to make it available as a legal medicine." The DEA Administrator rejected this conclusion, and the Court of Appeals for the District of Columbia Circuit affirmed.[3] The DEA, however, has its own Compassionate IND program where the federal government gives medical cannabis to a remaining handful of patients, as long as they are alive. In the past 25 years, NORML has litigated several times the issue of medical use of cannabis in federal courts and administratively before the DEA.[4] With reclassification blocked by the DEA, NORML has continued to advocate the medical use of cannabis and to support state and federal legislation and voter initiatives to that end.

The National Association of Criminal Defense Lawyers (NACDL) is the preeminent bar organization advancing the mission of the nation's criminal defense lawyers to ensure justice and due process for persons accused of crime. Founded in 1958, NACDL has more than 11,400 direct members and 80 state and local affiliate organizations with nearly 30,000 members committed to preserving the Bill of Rights. The American Bar Association recognizes NACDL as an affiliate organization on its House

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[2] *In The Matter of Marijuana Rescheduling Petition*, Docket No. 86-22 (Sept. 6, 1988).

[3] *Marijuana Scheduling Petition*, 54 Fed. Reg. 53767, 53784 (Dec. 29, 1988), *aff'd Alliance for Cannabis Therapeutics v. DEA*, 304 U.S. App. D.C. 400, 15 F.3d 1131 (1994).

[4] NORML has always been a party in the "marijuana rescheduling" cases seeking federal recognition of the medical use of cannabis. *See, e.g.*, the related cases of *Alliance for Cannabis Therapeutics v. DEA, supra; Alliance for Cannabis Therapeutics v. DEA*, 289 U.S. App. D.C. 214, 930 F.2d 936 (1994); *NORML v. DEA*, 182 U.S. App. D.C. 114, 559 F.2d 735 (1977); *NORML v. Ingersoll*, 162 U.S. App. D.C. 67, 497 F.2d 654 (1977).

There is another rescheduling case pending now, the petitioners being the Coalition for Rescheduling Cannabis, a consortium of eleven organizations, including NORML. The petition was filed with the DEA on October 9, 2002, but the DEA did not state that it formally accepted it until April 3, 2003. In July 2004, the DEA referred it to the Department of Health and Human Services under 21 U.S.C. § 811. (There are no docket numbers.)

of Delegates. NACDL promotes study and research in the field of criminal law. In furtherance of its objectives over the past decade, NACDL files approximately ten *amicus* briefs a year with this Court on criminal justice issues defending the Bill of Rights.

NORML and NACDL together filed an *amicus* brief in *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483 (2001).

The Washington Association of Criminal Defense Lawyers and the Oregon Criminal Defense Lawyers Association are both state affiliates of NACDL. Both states have medical marijuana laws, and the criminal defense lawyers in those states defend the rights of their clients to use medical marijuana.

The parties have consented to the filing of this *amici* brief on behalf of the respondents, and the letters of consent are filed with this brief.

SUMMARY OF ARGUMENT

I. A. This case is about the confluence of the state and individual rights: A state's capacity to legislate its public health policy, by choosing its own means and ends to achieve what it believes best serves the good of its people, when there is no superior or even competing federal interest; and, the right of personal medical choices of the chronically and terminally ill, made in consultation with their doctors. This state-federal conflict implicates several individual liberties intertwined under our Constitution: The right of the "pursuit of happiness" and liberty by the chronically and terminally ill; the right of citizens "to be let alone" by government in personal decisions; and substantive due process when there is no comparable federal interest in prohibiting the conduct at issue.

B. Many sick people are not aided at all by conventional drug therapy for serious medical conditions. Cannabis, however, may provide them relief that conventional drug therapy cannot. The medical use of cannabis has been recognized for at least 5,000 years. Hundreds of articles, books, and reports deal with the efficacy of cannabis for

medicinal use and reputable drug companies, still in existence, such as Eli Lilly & Co. and Parke, Davis & Co., sold it. Ten states with 22% of the nation's population, nearly one-quarter, have legalized the medical use of cannabis.

II. A. No form of legislation is more fundamental than the right of the people of the American states to enact laws by initiative. This power is reserved to the people and the states under the Ninth and Tenth Amendments. In the ten states where the people have determined by their political and legislative processes that medical use of cannabis for the chronically or terminally ill is a right and a choice made between doctor and patient, medical cannabis is elevated to a privacy and due process right. The federal government has a duty to respect these states' decisions, and has no law enforcement or public safety interest in criminalizing the medical use of cannabis in those states.

B. Unless the federal government has sought to preempt the field, which it expressly has not done with drug laws under the Controlled Substances Act, 21 U.S.C. § 903, the Supremacy Clause does not prohibit states from enacting laws in the same area.

III. There is a constitutional right of privacy and substantive due process right in the medical use of cannabis when the decision is made under state law between a doctor and a chronically or terminally ill patient seeking to preserve a tolerable quality of life, under three separate but interrelated constitutional theories:

A. The decision to use medical cannabis can be the difference between a horrible existence or a minimal quality of life as death approaches. When sentient life becomes almost unbearable, anything that improves it takes on constitutional dimension. People have the right to define their own concept of existence. That right is the essence of the natural law upon which the Declaration of Independence, its "pursuit of happiness" and due process of law are founded. *Cruzan* holds that due process includes protection of the quality of life, and that applies here.

B. Implicit in the Bill of Rights is the "right to be let alone" by government. In *Winston v. Lee,* this Court

recognized that some parts of the "right to be let alone" are more important than the government's interest in doing what it wants. The personal medical decision to use medical cannabis to alleviate suffering is such a right.

C. The right to medical use of cannabis is also protected by substantive due process because both pain relief and the use of medical cannabis are recognized in our "history, legal traditions, and practices." The right to substantive due process must insure that chronically and terminally ill Americans should have the right to doctor-approved medical use of cannabis if it alleviates their debilitating suffering or improves their quality of life in their time left before their death.

IV. The claim that federal drug law enforcement is harmed by medical use is untenable. Whatever one's stance on the "war on drugs," the prosecution of drug offenses by the state and federal governments will go on unabated even if state chartered cannabis buyers' clubs are permitted to operate. The class of potential offenders that the federal government has selected are not drug abusers, but patients with doctor recommendations for treatment. The law enforcement and judicial machinery otherwise never would waste resources on such offenders. This issue involves no meaningful interest of the federal government, other than an opportunity to make a symbolic political statement in the "war on drugs." Casualties in the "war on drugs" should not be the chronically and terminally ill who are aided by medical use of cannabis.

ARGUMENT

I. Introduction

A. What this case is and what it is not

Amici submit that the government trivializes the legal and health issues in this case by framing the issue as "*purported* personal 'medicinal' use or the distribution of marijuana without charge for such use." Petition at I (emphasis added). This case is about the bona fide medicinal use of cannabis by the chronically ill and dying in California where other medication has failed to alleviate

their condition, pursuant to an initiated act adopted by the people of California, and, by extension, in the nine other states that have legislatively legalized medicinal use of cannabis.

The Respondent medicinal cannabis-using patients assert the fundamental right to enhance the quality of whatever is left of their lives, when other more conventional treatment and medication have failed to relieve suffering. This case also concerns the fundamental right to exercise legislative power as reserved by the Ninth and Tenth Amendments, to the people of ten states, although only California is presently before the Court. Finally, this case presents an exercise of law enforcement authority by the federal government in a narrow area where it lacks any constitutional power to act under the Ninth and Tenth Amendment because this is a power reserved to the people and the States. On this record, there is utterly no federal interest in this case: the cannabis is locally grown, given away to those with a prescription, it is limited to those with a proven bona fide medical need, and there is no economic issue whatsoever in this case. Moreover, there is no indication in the Controlled Substances Act (CSA) that it is designed or intended to reach such activity because the CSA expressly permits the states to legislate as they please under 21 U.S.C. § 903.

Popularly enacted legislation permitting compassionate medical use of cannabis is an assertion of a fundamental right by the people and the states where the federal government has failed to act. Those state laws here recognize a right for patients who have lost any real quality of life from chronic or terminal illness to be free from unnecessary pain and suffering. Enabling patients whose medical conditions deny them a quality of life to use medical cannabis with their doctor's oversight is a matter fully reserved to the people and the states under the Ninth and Tenth Amendments that the federal government must respect. The federal government has no power to legislate in this area under either the commerce clause or "necessary and proper" clause of Art. I, § 8 of the Constitution. "The government . . . can claim no powers which are not granted to it by the Constitution, and the powers actually

granted, must be such as are expressly given, or given by necessary implication." *Martin v. Hunter's Lessee,* 14 U.S. (1 Wheat.) 304, 326 (1818).

This case involves numerous fundamental interests at risk in the attempt by the federal government to prohibit what California and nine other states have allowed. This exercise of rights by the people and the states to legislate in matters of personal human dignity is protected from federal abrogation or interference under our fundamental concept of ordered liberty and federalism. Where there is a personal medical choice made in consultation with a doctor, where there is no compelling conflicting federal interest, the people and states are constitutionally entitled to legislate what means they believe better serve their own defined goals. This conflict implicates multiple intertwined individual liberties under our Constitution: The right of the "pursuit of happiness" and liberty by the chronically and terminally ill; the right of people "to be let alone" by their government in these personal decisions; and substantive due process, particularly when there is no serious or even marginally compelling federal interest in prohibiting the conduct at issue.

B. The history, efficacy, and public acceptance of the medical use of cannabis

Cannabis has been recognized as having legitimate medical use for 5,000 years,[5] and possibly 10,000 years,[6]

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[5] LESTER GRINSPOON, M.D. & JAMES B. BAKALAR, MARIHUANA: THE FORBIDDEN MEDICINE 3-5 (Rev.ed. 1997) ("The first evidence of the medicinal use of cannabis is an herbal published during the reign of Chinese Emperor Chen Nung five thousand years ago. [¶] It was listed in the United States Dispensatory in 1854. . . . Commercial cannabis preparation could be bought in drug stores. . . . [¶] Meanwhile, reports on cannabis accumulated in the medical literature."). *See Regina v. Parker, infra,* ¶ 123:

> Like many other herbs, marihuana has been used in Asian and Middle Eastern countries for at least 2600 years for medicinal purposes. It first appeared in Western medicine in 60 A.D. in the Herbal (i.e. pharmacopoeia) of Dioscorides and was listed in subsequent herbals or pharmacopoeia since that

(Continued on following page)

including a wealth of modern articles on the utility of the medicinal use of cannabis, and the history of cannabis use in the United States beginning before our colonization.[7] The most recent books citing published findings are: LESTER GRINSPOON, M.D. & JAMES B. BAKALAR, MARIHUANA: THE FORBIDDEN MEDICINE (Rev.ed. 1997) and NATIONAL ACADEMY OF SCIENCES'S INSTITUTE OF MEDICINE, MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE (1999).[8] Indeed, medicinal cannabis was recognized in the medical literature of the United States since the mid-1800's.[9] Medical cannabis

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time. Marihuana was widely used for a variety of ailments, including muscle spasms, in the nineteenth century. In the 1930's, the advent of synthetic drugs led to the abandonment of many ancient herbal remedies including marihuana, although an extract of cannabis and a tincture of cannabis remained in the British Pharmaceutical Codex of 1949.

[6] Declaration of Lester Grinspoon, M.D., Appendix B.

[7] GRINSPOON & BAKALAR, *supra*, Ch. 1.

Some of our founding fathers were hemp growers. Bergoffen & Clark, *Hemp as an Alternative to Wood Fiber in Oregon*, 11 J.ENVTL.L. & LITIG. 119, 120-21 (1996):

> In North America, hemp was widely used before European settlement, contrary to popular views. . . . John De Verrazano discovered it growing wild in Virginia in 1524. It is also well established that marijuana has been used for both religious and recreational purposes for thousands of years.
>
> . . . In Virginia in the 1760s, a bounty of "four shillings for every gross hundred of hemp" was to be paid to farmers. Most famous of these Virginia hemp farmers were George Washington and Thomas Jefferson; Jefferson considered hemp so important that he even arranged to smuggle Chinese hemp seeds back to the United States because of their superior qualities. Another forefather, Benjamin Franklin, founded one of America's first paper mills which used hemp as its fiber source.

[8] The latter is online at http://bob.nap.edu/books/0309071550/html/, last visited Oct. 8, 2004.

[9] Grinspoon wrote, *supra*, note 5, that medical cannabis was in the UNITED STATES DISPENSATORY in 1854. Medicinal cannabis was distributed or recommended by all sorts of respected and well-known drug companies at the end of the Nineteenth Century and beginning of the Twentieth, companies still around today: *See, e.g.*,

(Continued on following page)

fell into disuse by the confluence of Prohibition and the development of patent medicines. Grinspoon Aff. ¶s 12-13, Appendix B. Dr. Grinspoon is the world's foremost authority on medicinal marijuana.

Even the DEA's ALJ recognized the case for the medical use of cannabis presented by NORML was *never refuted* by the agency. The DEA would not hear of it, however, and refused to adopt the ALJ's recommendation despite the uncontradicted evidence. (*See* notes 2-4, *supra*.) No wonder, then, that the states acted to legalize medicinal use of cannabis. The federal government must respect the choice of these states.

Many influential American and other medical organizations and health care providers today recognize that there is a bona fide need for the medical use of cannabis when a doctor and patient decide it is necessary. *See* Appendix A. This should be a fundamental personal choice in which the federal government should have no say.

Parke, Davis & Co.: INDEX OF DISEASES AND REMEDIES 192-93 (1890); PHYSICIAN'S MANUAL OF THERAPEUTICS 274-76 (1901); COMPLETE CATALOG OF THE PRODUCTS OF THE LABORATORIES OF PARKE, DAVIS & CO. (rev. Dec. 1, 1915, Jan. 2, 1927, Mar. 1, 1937).

Eli Lilly & Co.: *Lilly's Bulletin* (Feb. 1892); PHARMACEUTICAL CHEMISTS 32 (5th rev. 1898); HANDBOOK OF PHARMACY AND THERAPEUTICS 53, 71, 75 (6th rev. 1919).

Medical use of cannabis was also listed in the basic medical literature at the beginning of the Twentieth Century: *see, e.g.*, MORSE STEWART, M.D., POCKET THERAPEUTICS AND DOSE-BOOK 74 (4th ed. 1910); WALTER A. BASTEDO, M.D., MATERIA MEDICA: PHARMACOLOGY: THE THERAPEUTICS OF PRESCRIPTION WRITING 368 (1914); HOBART AMORY HARE, A TEXT-BOOK OF PRACTICAL THERAPEUTICS 166-68 (16th ed. 1916); THE PHARMACOPŒIA OF THE UNITED STATES OF AMERICA 95 (10th ed. 1926); *Id.* at 155 (11th ed. 1936); SAMUEL O.L. POTTER, M.D., THERAPEUTICS: MATERIA MEDICA AND PHARMACY 205-07 (14th ed. 1926); DAVID M.R. CULBRETH, M.D., A MANUAL OF MATERIAL MEDICA AND PHARMACOLOGY 165-70 (7th ed. 1927); A.S. BLUMGARTEN, M.D., TEXTBOOK OF MATERIA MEDICA 338-39 (5th ed. 1931); E. FULLERTON COOK, P.D., PH.M. & CHARLES H. LAWALL, PH.M, PHARM.D., REMINGTON'S PRACTICE OF PHARMACY 401, 413, 421, 456, 515 (8th ed. 1936); THE DISPENSARY OF THE UNITED STATES OF AMERICA 275-78 (22d ed. 1937). *See* also the authorities cited in note 5, *supra*.

II. Federalism and the Commerce Clause require that this Court recognize that medical use of cannabis is a matter reserved to the people and the States under the Ninth and Tenth Amendments

This case presents the recognition of important legal doctrines at the heart of our form of constitutional government: individual liberty and the powers reserved to the people and the States. As a matter of individual liberty, it should be beyond the power of the federal government to regulate the medicinal use of cannabis when the voters or legislatures of states decide it should be legalized for medical use. (Point III, *infra*) Ten states with 22% of the population have approved of the medical use of cannabis since 1996: Nine by initiative and one by the state legislature. The public and medical organizations strongly support medical cannabis use for those who would be aided by it. (Appendix A)

It is only natural, then, that the proponents of the medical use of cannabis go directly to the people when a state legislature or the federal government fails to act. It is, no doubt, a natural political right. And, as James Madison would say: It is none of the federal government's business.

A. Federalization of a purely local concern in violation of the Tenth Amendment

This case involves federalization of a quintessentially local activity: the production and consumption of purely locally grown and distributed cannabis solely for medicinal reasons by seriously ill Californians whose condition is not alleviated by other drugs.[10] It is undisputed on this record

[10] Oregon's Department of Human Services reports, as of July 1, 2004, 10,196 registered patients, 5,384 registered caregivers, and 1,413 registered physicians, with the following conditions described for the patients:

Conditions*

*A patient may have more than one diagnosed qualifying medical condition.

(Continued on following page)

that the cannabis involved here does not "substantially affect interstate commerce," *United States v. Lopez,* 514 U.S. 549, 559 (1995), or that any purported link to interstate commerce is attenuated at best. *United States v. Morrison,* 529 U.S. 598, 610-12 & n.4 (2000). It is a case involving respect for "the constitutional role of States as sovereign entities"; *Alden v. Maine,* 527 U.S. 706, 713 (1999); to prosecute their own crimes under the Tenth Amendment[11] because the Controlled Substances Act does not preempt state law. 21 U.S.C. § 903.

Agitation related to Alzheimer's disease	<50
Cachexia	438
Cancer	335
Glaucoma	198
HIV+/AIDS	221
Nausea	2134
Pain	8711
Seizures, including but not limited to epilepsy	316
Persistent muscle spasms, including but not limited to those caused by multiple sclerosis	2691

www.ohd.hr.state.or.us/publichealth/mm/ (last visited Oct. 8, 2004).

[11] *Printz v. United States,* 521 U.S. 898, 918 (1997):

> It is incontestible that the Constitution established a system of "dual sovereignty." *Gregory v. Ashcroft,* 501 U.S. 452, 457 (1991); *Tafflin v. Levitt,* 493 U.S. 455, 458 (1990). Although the States surrendered many of their powers to the new Federal Government, they retained "a residuary and inviolable sovereignty," THE FEDERALIST No. 39, at 245 (J. Madison) . . . Residual state sovereignty was also implicit, of course, in the Constitution's conferral upon Congress of not all governmental powers, but only discrete, enumerated ones, Art. I, § 8, which implication was rendered express by the Tenth Amendment's assertion that "[t]he powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

JAMES MADISON, THE FEDERALIST No. 39, *supra*:

> In the latter, the local or municipal authorities form distinct and independent portions of the supremacy, no more subject within their respective spheres of authority, than the general

(Continued on following page)

Amici submits that, in attempting to prosecute the crime of possession of cannabis for legitimate medical purposes, recognized by a sovereign state of the United States, the federal government exceeded its power under the Commerce Clause, Art. I, § 8, cl. 3, of the U.S. Constitution. To paraphase this case using *Lopez*:

> [t]he possession of a [medically prescribed cannabis] [o]n [ ] local [farm land or for local medical use] is in no sense an economic activity that might, through repetition elsewhere, substantially affect any sort of interstate commerce. Respondent was a local [medical user for himself] at a local [dispensary]; there is no indication that he had recently moved in interstate commerce, and there is no requirement that his possession of the [medically prescribed cannabis] ha[s] any concrete tie to interstate commerce.

Lopez, 514 U.S. at 567, quoted *infra* (bracketed material added).

This is an issue of first impression for this Court, and it was apparently reserved in *United States v. Oakland Cannabis Buyers' Coop.,* 532 U.S. 483, 495 n.7 (2001).[12]

Applying *Lopez* and its progeny, particularly *United States v. Morrison,* 529 U.S. 598, 610-12 (2000), the record here demonstrates that the use of medicinal cannabis here is not an economic or commercial enterprise, so *Wickard v. Filburn,* 317 U.S. 111 (1942), does not come into play under *United States v. Morrison,* 529 U.S. at 611 n.4. Second, the findings of Congress in 21 U.S.C. § 801 as to interstate character of drug trafficking has no application

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> authority is subject to them within its own sphere. In this relation then, the proposed government cannot be deemed a NATIONAL one; since its jurisdiction extends to certain enumerated powers only, and leaves to the several states a residuary and inviolable sovereignty over all other objects.

[12] *Oakland Cannabis,* 532 U.S. at 495 n.7: "Nor are we passing today on a constitutional question, such as whether the Controlled Substances Act exceeds Congress' power under the Commerce Clause."

to the facts on this record; just because Congress says it does not make it so, and this Court must look behind those findings. *Morrison,* 529 U.S. at 614; *Lopez,* 514 U.S. at 566-67. Finally, the link between the sought to be regulated activity and its effect on interstate commerce is "attenuated" at best. *Morrison, supra,* at 612.

B. The power of the people to initiate legislation is reserved to the people and the States by the Ninth and Tenth Amendments

The power of initiative and referendum appears in about half of the state constitutions,[13] as it does in California. Cal. Const., Art. 4, § 1. This quintessential reservation of political and legislative power is expressly reserved to the people and the States under the Ninth and Tenth Amendments.[14] In addition, the initiative power is clothed with full First Amendment protection as "core political speech" and a method of petitioning government for redress of grievances.[15]

As Justice STEVENS stated concurring on *Oakland Cannabis Buyers' Coop., supra,* 532 U.S. at 501, this Court, as a federal institution, must

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[13] *Lucas v. Forty-Fourth General Assembly,* 377 U.S. 713, 734 (1964).

[14] *Cammarano v. United States,* 358 U.S. 498, 506 (1959) (state constitutions "explicitly recognize that in providing for initiatives they are vesting legislative power in the people.").

[15] *See Meyer v. Grant,* 486 U.S. 414, 421-22 (1988):

> The circulation of an initiative petition of necessity involves both the expression of a desire for political change and a discussion of the merits of the proposed change. [A] petition circulator . . . will at least have to persuade them that the matter is one deserving of the public scrutiny and debate that would attend its consideration by the whole electorate. This will in almost every case involve an explanation of the nature of the proposal and why its advocates support it. Thus, the circulation of a petition involves the type of interactive communication concerning political change that is appropriately described as "core political speech."

> show[] respect for the sovereign States that comprise our Federal Union. That respect imposes a duty on federal courts, whenever possible, to avoid or minimize conflict between federal and state law, particularly in situations in which the citizens of a State have chosen to serve as a laboratory in the trial of novel social and economic experiments without risk to the rest of the country. (internal quotation marks omitted)

C. Federal deference to state law on the medical use of cannabis, and the inapplicability of the Supremacy Clause

Once the voters of a state have adopted an initiative or a state legislature has enacted a statute protecting the medical use of cannabis, the people of that state have compellingly expressed their public policy, even if that public policy differs from that of the federal government. Federalism mandates that state public policy is entitled to presumptive deference. State legislation expresses its public policy; *Schall v. Martin,* 467 U.S. 253, 281 (1984); especially legislation adopted directly by the people.[16]

The Supremacy Clause, U.S. Const., Art. IV, cl. 2, provides the federal government no support in its attempt to nullify this state law because Congress has not even remotely attempted to preempt every part of the field of criminalizing drug crimes; indeed, 21 U.S.C. § 903 expressly allows the States to legislate as they choose, and every state has laws against the illegal use, manufacture, and distribution of controlled substances. And, the federal government could not preempt drug regulation even if it wished, because the federal government possesses no

[16] Also, "state legislatures are *not* subject to federal direction. *New York v. United States,* 505 U.S. 144 (1992)." *Printz v. United States,* 521 U.S. 898, 912 (1997) (emphasis in original).

A fortiori, if a legislature is not subject to federal direction, neither are the people acting through the initiative process.

general federal police power, a power singularly reserved to the states. *Lopez v. United States,* 514 U.S. at 560 n.3.

Federal and state drug laws have co-existed for more than 60 years, and state laws recognizing medical use of cannabis manifestly do not "'stand[] as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'" *Pacific Gas & Electric Co. v. State Energy Resources Conservation and Development Comm.,* 461 U.S. 190, 203-04 (1983) (quoting *Hines v. Davidowitz,* 312 U.S. 52, 67 (1941)). The federal government can fully prosecute the more significant drug crimes as it should and just stay out of the business of the states.[17]

Congress cannot remain in denial of factual reality and cannot declare night to be day and simply expect this Court to rubberstamp that conclusion any more. *Lopez,* 514 U.S. at 566-67. In the realm of state and federal drug offenses, *Kelly v. Washington ex rel. Foss Co.,* 302 U.S. 1, 9-10 (1937), answers this question for us:

> Under our constitutional system, there necessarily remains to the States, until Congress acts, a wide range for the permissible exercise of power appropriate to their territorial jurisdiction although interstate commerce may be affected. . . . States are thus enabled to deal with local exigencies and to exert in the absence of conflict with federal legislation an essential protective power. And when Congress does exercise its paramount authority, it is obvious that Congress may determine how far its regulation shall go. There is no constitutional rule which compels Congress to occupy the whole field. Congress may circumscribe its regulation and occupy only a limited field. When it does so, state regulation outside that limited field and otherwise admissible is not

[17] The federal government still dabbles in medicinal cannabis use, actually providing it to a declining (as they die off) number of patients. If the states want to explore this further, the federal government should just stay out of it.

> forbidden or displaced. The principle is thoroughly established that the exercise by the State of its police power, which would be valid if not superseded by federal action, is superseded only where the repugnance or conflict is so "direct and positive" that the two acts cannot "be reconciled or consistently stand together." (citations omitted)

Thus, unless Congress dictates that the states may not regulate drug crimes, something it will never do, the federal government cannot claim preemption. Indeed, the CSA says otherwise in 21 U.S.C. § 903.

III. The right of liberty, privacy, and substantive due process in medical use of cannabis

There is a constitutional right of privacy and a substantive due process right in the medical use of cannabis when that decision is made under state law between a doctor and a chronically or terminally ill patient seeking to preserve a tolerable quality of life. This right is more significant when patients seek to preserve some semblance of human dignity and freedom from the ravages of disease in their final days. This principle is founded on three interrelated constitutional theories:

A. Rights to the dignity of life, individual liberty and autonomy, and the "pursuit of happiness"

For some patients, the decision to use medical cannabis can be the difference between a horrible existence or a minimal quality of life as death approaches. When a state has permitted the use of medical cannabis for these people, after conventional medication has failed or forced them to suffer intolerable side effects, their very ability to define their life is at stake. When the quality of life becomes almost unbearable, anything that improves the quality of life has constitutional dimension. "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define

the attributes of personhood were they formed under compulsion of the State." *Planned Parenthood of Southeastern Pa. v. Casey,* 505 U.S. 833, 850-51 (1992).

Indeed, "defin[ing] one's own concept of existence" is the essence of the natural law expressed in ¶ 2 of the Declaration of Independence: "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty, and the pursuit of Happiness." As the Court stated in *Board of Regents v. Roth,* 408 U.S. 564, 572 (1972), the Court has not attempted to define with exactness the liberty guaranteed by due process, because, "[i]n a Constitution for a free people, there can be no doubt that the meaning of 'liberty' must be broad indeed." In Respondent Angel Raich's situation, liberty is having any quality of life at all. Cannot the federal government do anything to insure the quality of life rather than interfere with it?

> Our Constitution is born of the proposition that all legitimate governments must secure the equal right of every person to "Life, Liberty, and the pursuit of Happiness." In the ordinary case we quite naturally assume that these three ends are compatible, mutually enhancing, and perhaps even coincident.
>
> . . . Together, these considerations suggest that Nancy Cruzan's liberty to be free from medical treatment must be understood in light of the facts and circumstances particular to her.

Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 331 (1990) (STEVENS, J., dissenting) (footnote omitted).

A state has an "unqualified interest in the preservation of human life." *Cruzan,* 497 U.S. at 282. Because of that interest, states sometimes seek the preservation of life notwithstanding the utter lack of quality of that life. Thus, Nancy Cruzan's family had to fight the State of Missouri which wanted to keep her alive by state mandated medical intervention. Like the state in *Cruzan,* the federal government tells us that patients who want to

preserve their own life, who are struggling to stay alive despite painful or debilitating side effects of modern medicine, have no right to preserve any semblance of dignity of their waning life by medical procedures approved by the voters of their state. The sovereign State of California, a state of over 35 million people, through its voters, have determined that the interest in the quality of life for the gravely ill by giving them relief from their condition, when other medicines have failed,[18] is more important than prosecution of those people for possession or cultivation or delivery of cannabis for medicinal purposes.

Is it not ironic that a prison inmate can be judicially forced to be medicated to have a quality of life on death row for the temporary preservation of his life, just so the state can later be able to execute him?[19] Yet here, the government denies a comparable right to the chronically or terminally ill patient who could benefit from the medical use of cannabis. This judicial distinction, to heal prisoners to enable the states to end their life, but to harm terminal patients holding on to life, is irrational and contrary to any concept of ordered liberty in a free nation.

If a state has such an "unqualified interest in the preservation of life," it must of necessity also have an interest in the quality of the life it preserves as the end of life approaches. In some situations, particularly the AIDS wasting syndrome, the medical use of cannabis usually provides the *only means to sustain life*. If so, then there

[18] *See, e.g., Regina v. Parker, infra,* where the Ontario Court of Appeals, in holding that medicinal use of cannabis was a right in Canada, noted that synthetic THC (Marinol®) failed Parker, but cannabis alleviated his suffering.

[19] A state may force inmates to take anti-psychotic medication to restore sanity when they are so disturbed that they have no quality of life and are a danger to themselves or others; *Washington v. Harper,* 494 U.S. 210 (1990); even if this medical intervention is forced on them, would make the inmates competent, and thus enable the state to execute them. *Singleton v. Norris,* 338 Ark. 135, 992 S.W.2d 768 (1999), *cert. den.* 528 U.S. 1084 (2000); *Singleton v. Norris,* 319 F.3d 1018 (8th Cir. 2003) (*en banc*), *cert. den.* 124 S. Ct. 74 (2003).

should be a constitutional right to use it, and, if there is no constitutional right, then the states should be freely able to legislate it.

B. The right to privacy in "the right to be let alone" by government

There is a basic right to privacy in this nation, "the right to be let alone," and it runs throughout the law of individual liberty. Whatever its source, be it in the common law,[20] the law of torts,[21] the Ninth Amendment, one of those "penumbra" rights within the Bill of Rights as a whole,[22] or whether it is a liberty interest under the due

[20] *See Union Pac. Ry. Co. v. Botsford,* 141 U.S. 250, 251 (1891), where a railroad sought a physical examination of an injured passenger. This Court affirmed the lower court's refusal to permit the examination of her body so the railroad could separately evaluate the seriousness of her injury:

> No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. As well said by Judge Cooley: "The right to one's person may be said to be a right of complete immunity; to be let alone." Cooley, Torts, 29.

See Poe v. Ullman, 367 U.S. 497, 521 & n.12 (1961) (DOUGLAS, J., dissenting) ("The notion of privacy is not drawn from the blue. [n12: The right 'to be let alone' had many common-law overtones.] It emanates from the totality of the constitutional scheme under which we live.") & 543 (HARLAN, J., dissenting) (in addition, it protects against "arbitrary impositions and purposeless restraints" by government (quoting *Hurtado v. California,* 110 U.S. 516, 632 (1884)).

[21] *See generally* Warren & Brandeis, *The Right to Privacy,* 4 HARV. L. REV. 193 (1890); Prosser, *Privacy,* 48 CALIF. L. REV. 391 (1960); Griswold, *The Right to be Let Alone,* 55 NW. U. L. REV. 216 (1960).

[22] *Griswold v. Connecticut,* 381 U.S. 479, 484 (1965) (there is a penumbra of privacy rights, "zones of privacy," in the First, Third, Fourth, and Ninth Amendments); *Lawrence v. Texas,* 123 S. Ct. 2472 (2003) (states have no interest in prosecuting private consensual sex acts).

process clauses of the Fifth and Fourteenth Amendments,[23] government must recognize that certain rights reserved to the people and states are beyond its reach.

The phrase was truly memorialized in Justice Brandeis's famous dissent 76 years ago in *Olmstead v. United States,* 277 U.S. 438, 478 (1928):

> The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone – the most comprehensive of rights and the right most valued by civilized men. To protect that right, every unjustifiable intrusion by the Government upon the privacy of the individual, whatever the means employed, must be deemed a violation of the Fourth Amendment.[24]

While the "right to be let alone" originally emerged into this Court's cases in a dissent, the existence of a constitutional right "to be let alone" is now well accepted. The Court has repeatedly cited *Olmstead* and considered "the right to be let alone" as a part, not only of the Fourth Amendment,[25]

[23] *Id.*, 381 U.S. at 493 (GOLDBERG, J., concurring) (due process and Ninth Amendment), 500 (HARLAN, J., concurring) (basic to concept of "ordered liberty" for due process) & 507 (WHITE, J., concurring) (due process violated because government cannot pass such a law); *Cruzan,* 497 U.S. at 279 n.7 (liberty interest under the Fourteenth Amendment in refusing medical treatment with a "right to die").

[24] Justice BRANDEIS also said, *id.* at 479: "The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding."

[25] *California Bankers Assn. v. Shultz,* 416 U.S. 21, 65 (1974); *Winston v. Lee,* 470 U.S. 753, 758-59 (1985). *See Katz v. United States,* 389 U.S. 347, 350-51 & n.6 (1967).

but also the First,[26] Fifth,[27] and Fourteenth[28] Amendments, not to mention the Ninth Amendment.[29]

The "right to be let alone" has been found to outweigh even one of the weightiest of governmental interests: The interest in procuring evidence to prosecute a violent crime. In *Winston v. Lee,* 470 U.S. 753, 765-66 (1985), the Court denied the government the ability to obtain evidence by forced major surgery on the body of the accused to remove a bullet, even where the search would certainly produce evidence of a violent crime:

> The Fourth Amendment protects "expectations of privacy," see *Katz v. United States,* 389 U.S. 347 (1967) – the individual's legitimate expectations that in certain places and at certain times he has "the right to be let alone – the most comprehensive of rights and the right most valued by civilized men." *Olmstead v. United States,* 277 U.S. 438, 478 (1928) (BRANDEIS, J., dissenting). Putting to one side the procedural protections of the warrant requirement, the Fourth Amendment generally protects the "security" of "persons, houses, papers, and effects" against official intrusions up to the point where the community's need for evidence surmounts a specified standard, ordinarily "probable cause." Beyond this point, it is ordinarily justifiable for the community to demand that the individual give up some part of his interest in privacy and security to advance the community's vital interests in law enforcement; such a search is generally "reasonable" in the Amendment's terms.

[26] *Stanley v. Georgia,* 394 U.S. 557, 564 (1969); *Rowan v. U.S. Post Office Dept.,* 397 U.S. 728, 736 (1970).

[27] *Tehan v. United States ex rel. Shott,* 382 U.S. 406, 416 (1966). *See United States v. Morton Salt Co.,* 338 U.S. 632, 651-52 (1950).

[28] *Eisenstadt v. Baird,* 405 U.S. 438, 453-54 n.10 (1972).

[29] *See Griswold v. Connecticut, supra.*

But, the Court held that this compelled surgical intrusion for evidence implicated expectations of privacy and personal security to such a degree that the intrusion was constitutionally unreasonable under the Fourth Amendment even though it certainly would produce evidence of a violent crime. *Id.* at 758-59. The government's normally compelling need to obtain vital evidence to enforce the criminal law and prosecute a violent criminal constitutionally had to give way to the personal dignity of the individual because the search was "unreasonable" under the Fourth Amendment.

That rationale applies with equal force here: No matter what the governmental interest in prosecuting drug crimes, the personal and fundamental interest in preserving the dignity of life should weigh more heavily, particularly when a sovereign state, the largest in the nation, no less, with nearly 35 million people, has declared its public policy through a vote of the people, that its citizens are entitled to the benefit of the medical use of cannabis in small quantities, locally produced.

C. Substantive due process: "history, legal traditions, and practices"

Analogous to the above two standards and using similar language, but still clearly a standard of its own, is the right to substantive due process under the Fifth and Fourteenth Amendments. If the right to substantive due process means anything, it should mean that chronically and terminally ill Americans should have the right to medical use of cannabis if it alleviates suffering from a serious medical condition and thereby adds some quality of life in the time left before death. This Court has already recognized a substantive due process right to be free from pain and suffering in *Cruzan,* involving a woman who was in a persistent vegetative state whose family wanted to have a feeding tube withdrawn so she could die and be allowed to be free of her misery. *A fortiori,* it naturally flows from that case that there also is a parallel right patients in chronic pain or the terminally ill to alleviate

pain and suffering *when they want to live.* Nancy Cruzan had a right to stop being force fed and to die to alleviate her pain and suffering that was caused merely by her being kept alive in that condition. For patients who, with their doctors' approval, want to go on living but without their pain and suffering, they also have an "unqualified interest in the preservation of human life." "Life" must also mean "quality of life," however the states chose to permit it.

After *Cruzan,* this Court held in *Washington v. Glucksberg,* 521 U.S. 702 (1997), that there was no due process right to assisted suicide. The Court stated its approach to due process issues; *id.* at 710:

> We begin, as we do in all due-process cases, by examining our Nation's history, legal traditions, and practices. *See, e.g., Casey,* 505 U.S. at 849-850; *Cruzan,* 497 U.S. at 269-279; *Moore v. East Cleveland,* 431 U.S. 494, 503 (1977) (plurality opinion) (noting importance of 'careful "respect for the teachings of history" ')."

This substantive due process analysis derives from Justice HARLAN'S dissent in *Poe v. Ullman,* 367 U.S. 497, 542-43 (1961), elucidating the true meaning of "the full scope of liberty" under due process:

> It is this outlook which has led the Court continuingly to perceive distinctions in the imperative character of Constitutional provisions, since that character must be discerned from a particular provision's larger context. And inasmuch as this context is one not of words, but of history and purposes, the full scope of the liberty guaranteed by the Due Process Clause cannot be found in or limited by the precise terms of the specific guarantees elsewhere provided in the Constitution. This "liberty" is not a series of isolated points pricked out in terms of the taking of property; the freedom of speech, press, and religion; the right to keep and bear arms; the freedom from unreasonable searches and seizures; and so on. It is a rational continuum which,

> broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints, . . . and which also recognizes, what a reasonable and sensitive judgment must, that certain interests require particularly careful scrutiny of the state needs asserted to justify their abridgment. . . . (citations omitted)

Justice HARLAN'S opinion in *Poe* is recognized as the source of modern individual judicial review of substantive due process claims.[30]

Finally, in *Lawrence v. Texas,* 539 U.S. 558 (2003), this Court held that private consensual sex acts between adults could not be legislatively prohibited as a matter of due process. It was, simply put, no interest of state government. Where is the interest of the federal government in prohibiting medicinal marijuana when states authorize it? The personal decision to use medicinal cannabis to relieve pain and suffering, *when authorized by a state*, in consultation with a doctor, should be no less than the right to personal sexual autonomy when not authorized by a state, simply because due process demands it of the federal government.

[30] *Washington v. Glucksberg, supra,* at 766 n.4 (SOUTER, J., dissenting):

> The status of the Harlan dissent in *Poe v. Ullman,* . . . , is shown by the Court's adoption of its result in *Griswold v. Connecticut,* . . . , and by the Court's acknowledgment of its status and adoption of its reasoning in *Planned Parenthood of Southeastern Pa. v. Casey,* 505 U.S. 833, 848-849 (1992). See also *Youngberg v. Romeo,* 457 U.S. 307, 320 (1982) (citing Justice HARLAN's *Poe* dissent as authority for the requirement that this Court balance "the liberty of the individual" and "the demands of an organized society"); *Roberts v. United States Jaycees,* 468 U.S. 609, 619 (1984); *Moore v. East Cleveland,* 431 U.S. 494, 500-506, and n.12 (1977) (plurality opinion) (opinion for four Justices treating Justice HARLAN's *Poe* dissent as a central explication of the methodology of judicial review under the Due Process Clause).

Our "history, legal traditions, and practices" unequivocally tell us that the individual is more important than the government and that government interference with a person's autonomy must be based on extremely important societal interests. In some cases, an individual's right to personal autonomy can outweigh even the undeniable powerful governmental interest in prosecuting violent crime, as in *Winston v. Lee.* Similarly, the right to personal autonomy in a private sexual act outweighs the government's power to criminalize, as in *Lawrence v. Texas.* We must never forget that our government exists to serve its citizens; the citizens do not exist to serve the government.[31] Moreover, medical use of cannabis is a part of our nation's history and the history of civilization for the last 5,000 or even 10,000 years. State authorized medical use of cannabis for patients with a dire need thus clearly qualifies for recognition under substantive due process "by examining our Nation's history, legal traditions, and practices."

D. The experience of Canada, Holland, and England

Canada's Charter of Rights was adopted only two decades ago, and it closely parallels our Bill of Rights; so much, indeed, that the Canadian courts apply American case law as an aid in interpreting their Charter.[32] Similarly, because of our geographic proximity and open border, political alliances, and similar adversary system with the same common law origin, this Court has looked to

[31] *See* the Declaration of Independence ¶s 3 & 28. *See also McCulloch v. Maryland,* 17 U.S. (4 Wheat.) 316, 405 (1819) ("The government . . . is emphatically, and truly, a government of the people. In form and in substance it emanates from them. Its powers are granted by them, and are to be exercised directly on them, and for their benefit.").

[32] *Regina v. Carter,* 2 C.R.R. 280, 144 D.L.R.(3d) 301, 304-05 (Ont. Ct. App. 1982) (American decisions may be persuasive). For example, running obvious queries ("U.S.," "F.3d," "Fourth Amendment") through their case data base on Lexis® will produce over 1,000 hits.

Canadian law and experience as an aid in interpreting our Bill of Rights.[33]

Section 7 of the Canadian Charter of Rights and Freedoms is the Canadian version of our Due Process Clause, and it provides that "[e]veryone has the right to life, liberty and security of the person and the right not to be deprived of those rights except in accordance with the principles of fundamental justice." The Ontario Court of Appeals found a fundamental right in the medical use of cannabis for the chronically ill, just as asserted here. The Canadian government has implementing medical use for distribution through its national health care system.[34] Thus, there is a right to the needful medical use of cannabis, notwithstanding that possession and delivery of cannabis otherwise remains a crime in Canada. *Regina v. Parker,* 49 O.R.(3d) 481, 75 C.R.R.(2d) 233, 188 D.L.R.(4th) 385, 2000 C.R.R. Lexis 96 (Ont. Ct. App. 2000) (right to use cannabis to control epilepsy; Marinol® was not helpful to Parker but cannabis was; medical necessity defense sustained as a fundamental right); *Regina v. Clay,* 49 O.R.(3d) 577, 75 C.R.R.(2d) 210, 188 D.L.R.(4th) 468, 2000 C.R.R. Lexis 97 (Ont. Ct. App. 2000) (no fundamental right to recreational possession of marijuana notwithstanding *Parker*'s recognition of a medical necessity right; both decided same day), *aff'd* [2003] 35 C.R. 735, 2003 S.C.C. 75, 2003 S.C.R. Lexis 675.

Parker was thus held to have a complete defense to criminal prosecution for his possession and cultivation of cannabis for his personal medical use. The Canadian

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[33] *See, e.g., Nixon v. Shrink Missouri Gov't PAC,* 528 U.S. 377, 403 (2000) (BREYER and GINSBURG, JJ, concurring); *Washington v. Glucksberg, supra,* at 713 (noting that Canadian courts had recently rejected a right to assisted suicide); *McIntyre v. Ohio Election Comm.,* 514 U.S. 334, 381 (1995) (SCALIA, J., dissenting).

[34] Harris, "Rock feels road to the PMO begins as a good health minister," *The Ottawa Citizen* A13, ¶ 14 (Jan. 28, 2001) (describing how the new health minister "has managed to get a formal medical-marijuana policy in place in Canada, including the identification of a supplier for the otherwise illegal drug.").

court's analysis in *Parker* closely parallels this Court's own due process analysis:

> [¶ 96] . . . "[s]ection 7 is also implicated when the state restricts individuals' security of the person by interfering with, or removing from them, control over their physical or mental integrity". There is no question, then, that personal autonomy, at least with respect to the right to make choices concerning one's own body, control over one's physical and psychological integrity, and basic human dignity are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these. . . .
>
> [¶ 102] In my view, Parker has also established that the marihuana prohibition infringed the second aspect of liberty that I have identified – the right to make decisions that are of fundamental personal importance. As I have stated, the choice of medication to alleviate the effects of an illness with life-threatening consequences is a decision of fundamental personal importance. In my view, it ranks with the right to choose whether to take mind-altering psycho-tropic drugs for treatment of mental illness, a right . . . ranked as "fundamental and deserving of the highest order of protection" in *Fleming v. Reid* (1991). . . .

Also within the last five years, Holland and England have recognized the medical value of cannabis and supported research and public distribution systems.

The Ontario court's approach underscores the utter implausibility of the government's position here: The Canadian government has no trouble prosecuting recreational marijuana cases despite a fundamental right to medical use, but the United States government thinks otherwise. The law enforcement interest, if it exists at all (and, in light of *Winston v. Lee* and *Lawrence v. Texas*, we do not agree that it does), is not remotely or legitimately limited or harmed by medical use legislation. They can co-exist, and they do

in California. As happened here, the Butte County Sheriff's Office was ready to leave Respondent Monson's six marijuana plants alone, fully recognizing her state right to possess them, but the DEA thought otherwise and destroyed them. *Raich v. Ashcroft,* 352 F.3d 1222, 1225-26 (9th Cir. 2003).

E. Civilized notions of personal liberty require this Court to recognize a constitutional right to state-chartered doctor-supervised treatment that is superior to any interest in federal prohibition

Fundamental notions of personal liberty under our scheme of constitutional government and federalism require this Court to recognize that, when a state has explicitly permitted its citizens the medical use of cannabis when doctor and patient agree, there is a fundamental constitutional right to the use of medical cannabis, free from unreasonable federal interference.

IV. Any claim that federal drug law enforcement is harmed by the California Compassionate Use Act of 1996 is untenable

Proposition 215, the California Compassionate Use Act of 1996, has had no material effect on the federal government's law enforcement machinery. Until California began its Compassionate Use Act, the federal government never wasted the time and resources of the DEA and the U.S. Attorney's Offices on such small cases. Arrests, searches and seizures, and prosecutions by the federal government in the face of the California Compassionate Use Act are brought merely to show California voters "who is the boss" by showing that the federal government is fighting the "war on drugs," ignoring the fact that the chronically ill in California are the casualties in this war. The federal government's resources are better spent on other aspects of the "war on drugs" where it can claim that it really believes a drug is a danger to society.

All states and federal government will continue to fight the "war on drugs," notwithstanding Proposition 215 and the laws of the nine other states legitimizing medicinal use of cannabis. California continues to vigorously prosecute marijuana possession cases that do not involve legitimate medical uses. *See* Brief of Reason Foundation as *Amicus Curiae* in Support of Respondents.

The federal spending on the war on drugs has increased seven-fold in 15 years,[35] and the number of people incarcerated for drug crimes has grown 1,000% in twenty years, including California under Proposition 215.[36] The war on drugs, however, has done absolutely nothing to prevent teenagers from experimenting with cannabis.[37] The government's ability to prosecute those who import, grow, and deal marijuana for profit has been unimpeded by Proposition 215 and the laws of the other nine states recognizing medical cannabis. This will not change, and the sky will not fall if Respondents prevail.

The federal government virtually *never* prosecutes cases involving individual users of small amounts of marijuana. The states do because it falls within *their* police power and *not* the federal government's. This fact only adds to the conclusion that is no meaningful federal interest involved in interfering with the vote of the citizens of California in adopting Proposition 215. Casualties

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[35] The Office of National Drug Control Policy FY 1985 budget was $2.7 billion. The FY 2001 proposed budget is $19.2 billion. THE NATIONAL DRUG CONTROL STATEGY: FY 2001, BUDGET SUMMARY 2000 ANNUAL REPORT, Table 3 <http://www.whitehousedrugpolicy.gov/policy/budget00/exec_summ.html#table3>.

[36] There are now more than 450,000 drug offenders behind bars, a total nearly equal to the entire U.S. prison population of 1980. SCHIRALDI & ZIEDENBERG, POOR PRESCRIPTION: THE COST OF IMPRISONING DRUG OFFENDERS IN THE UNITED STATES, Justice Policy Institute (2000).

[37] U.S. DEPT. OF HEALTH AND HUMAN SERVICES, MONITORING THE FUTURE NATIONAL RESULTS ON ADOLESCENTS' DRUG USE: OVERVIEW OF KEY FINDINGS, Table 9: Long-Term Trends in Perceived Availability of Drugs by Twelfth Graders: Marijuana 1975-2000 (2001).

in the "war on drugs" should not be the chronically and terminally ill who are aided by medical use of cannabis.

If our Constitution means anything, it should mean that "the war on drugs" cannot be made to be a war on the quality of life of the chronically or terminally ill. Sadly, for the sake of public respect for our government, the government believes in and promotes a constitutional regime that enables the federal government to enforce its policies which only serve to enhance patient pain contrary to state law and in denigration of the principles embodied in the Ninth and Tenth Amendments and to elementary notions of federalism. This Court must reject any such a view of the federal law and the Constitution that violates the rights of both citizens and the states to enact laws for their common good where there is no federal interest and where the federal government expressly disclaimed any interest in preemption under 21 U.S.C. § 903.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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October 2004

APPENDIX A

HEALTH ORGANIZATIONS SUPPORTING IMMEDIATE LEGAL ACCESS TO MEDICAL MARIJUANA AND THEIR POSITION STATEMENTS

International and National Organizations

AIDS Action Council
AIDS Treatment News
American Academy of Family Physicians
American Medical Student Association
American Nurses Association
American Preventive Medical Association
American Public Health Association
American Society of Addiction Medicine
Arthritis Research Campaign (England)
Australian Medical Association (New South Wales) Limited
Australian National Task Force on Cannabis
Belgian Ministry of Health
British House of Lords Select Committee on Science and Technology
British House of Lords Select Committee on Science and Technology (Second Report)
British Medical Association
Canadian AIDS Society (Societe Cannadienne du Sida)
Canadian Special Senate Committee on Illegal Drugs
Dr. Dean Edell (surgeon and nationally syndicated radio host)
Federation of American Scientists
French Ministry of Health
Health Canada
Kaiser Permanente
Lymphoma Foundation of America
Montel Williams MS Foundation
Multiple Sclerosis Society (Canada)
Multiple Sclerosis Society (England)

National Academy of Sciences Institute of Medicine (IOM)
National Association for Public Health Policy
National Nurses Society on Addictions
Netherlands Ministry of Health
New England Journal of Medicine
New South Wales (Australia) Parliamentary Working Party on the Use of Cannabis for Medical Purposes
Dr. Andrew Weil (nationally recognized professor of internal medicine)

State and Local Organizations

Alaska Nurses Association
Being Alive: People with HIV/AIDS Action Committee (San Diego, CA)
California Academy of Family Physicians
California Nurses Association
California Pharmacists Association
Colorado Nurses Association
Florida Governor's Red Ribbon Panel on AIDS
Florida Medical Association
Hawaii Nurses Association
Medical Society of the State of New York
Mississippi Nurses Association
New Mexico Nurses Association
New York County Medical Society
New York State Nurses Association
North Carolina Nurses Association
Report of the Medical Marijuana Study Committee (Vermont)
Rhode Island Medical Society
Rhode Island State Nurses Association
San Francisco Mayor's Summit on AIDS and HIV
San Francisco Medical Society
Virginia Nurses Association
Whitman-Walker Clinic (Washington, DC)
Wisconsin Nurses Association

Additional AIDS Organizations

(The following organizations are signatories to a February 17, 1999 letter to the US Department of Health petitioning the federal government to "make marijuana legally available . . . to people living with AIDS.")

AIDS Action Council
AIDS Foundation of Chicago
AIDS National Interfaith Network (Washington, DC)
AIDS Project Arizona
AIDS Project Los Angeles
Being Alive: People with HIV/AIDS Action Committee (San Diego, CA)
Boulder County AIDS Project (Boulder, CO)
Colorado AIDS Project
Center for AIDS Services (Oakland, CA)
Health Force: Women and Men Against AIDS (New York, NY)
Latino Commission on AIDS
Mobilization Against AIDS (San Francisco, CA)
Mothers Voices to End AIDS (New York, NY)
National Latina/o Lesbian, Gay, Bisexual And Transgender Association
National Native American AIDS Prevention Center
Northwest AIDS Foundation
People of Color Against AIDS Network (Seattle, WA)
San Francisco AIDS Foundation
Whitman-Walker Clinic (Washington, DC)

Other Health Organizations

(The following organizations are signatories to a June 2001 letter to the US Department of Health petitioning the federal government to "allow people suffering from serious illnesses . . . to apply to the federal government

for special permission to use marijuana to treat their symptom")

Addiction Treatment Alternatives
AIDS Treatment Initiatives (Atlanta, GA)
American Public Health Association
American Preventive Medical Association
Bay Area Physicians for Human Rights
(San Francisco, CA)
California Legislative Council for Older Americans
California Nurses Association
California Pharmacists Association
Embrace Life (Santa Cruz, CA)
Gay and Lesbian Medical Association
Hawaii Nurses Association
Hepatitis C Action and Advisory Coalition
Life Extension Foundation
Maine AIDS Alliance
Minnesota Nurses Association
Mississippi Nurses Association
National Association of People with AIDS
National Association for Public Health Policy
National Women's Health Network
Nebraska AIDS Project
New Mexico Nurses Association
New York City AIDS Housing Network
New York State Nurses Association
Ohio Patient Network
Okaloosa AIDS Support and Information Services
(Fort Walton, FL)
Physicians for Social Responsibility – Oregon
San Francisco AIDS Foundation
Virginia Nurses Association
Wisconsin Nurses Association

APPENDIX B

No. 03-1454

In The
United States Supreme Court

JOHN ASHCROFT, ATTORNEY GENERAL, *ET AL.*,
Petitioner,

v.

ANGEL MCCLARY RAICH, *ET AL*,
Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit

DECLARATION OF LESTER GRINSPOON, M.D., IN SUPPORT OF THE BRIEF OF *AMICI CURIAE* NATIONAL ORGANIZATION FOR THE REFORM OF MARIJUANA LAWS (NORML) AND THE NORML FOUNDATION

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October 2004

I, LESTER GRINSPOON, M.D., declare:

1. I am an Associate Professor of Psychiatry (emeritus), at Harvard Medical School in Boston, Massachusetts, where I have taught for more than 35 years. I am also the Founding Editor of The Harvard Mental Health Letter. My area of research is psychoactive drugs. I am particularly interested in the medicinal properties of cannabis. For the Court's convenience, where appropriate I have provided footnotes referencing the sources upon which I have relied.

2. I received a Bachelor of Science degree in 1951 from Tufts College and a Doctorate of Medicine in 1955 from Harvard Medical School. I subsequently completed and [sic] internship in medicine at Beth Israel Hospital in Boston, Massachusetts (1955-1956), and a residency in psychiatry at Massachusetts Mental Health Center (1958-1961). I received further training as a field instructor for the National Cancer Institute in Los Angeles, California (1956-1958).

3. Since joining the Harvard Medical School faculty in 1961, I have held numerous positions, including Assistant Clinical Professor, Associate Clinical Professor and Associate Professor at the Harvard Medical School. My other research and teaching appointments include: Assistant in Medicine at the University of Southern California School of Medicine (1956-1958), Director of the Clinical Research Center for the Massachusetts Mental Health Center (1961-1968), Consultant in Psychiatry and Research for Boston State Hospital (1963-1970) and an Examiner for the American Board of Psychiatry and Neurology (1969-1980). I have also held several positions for the American Psychiatric Association such as Vice-Chairperson (1975-1977) and Chairperson for the Council on Research

(1977-1979); Vice-Chairperson (1979-1980) and Chairperson for the Scientific Program Committee (1980-1984).

4. I serve on several professional and community boards. These include many years as a member of the Beneficial Plant Research Association (1980-1984), the Drug Policy Foundation (1987-1995), Physicians for Human Rights (1986-present), the Drug Research Group (1995-present), and Scientific and Policy Advisors of the American Council on Science and Health (1997-present). I recently served as Chairperson for the Board of Directors for the National Organization for the Reform of Marijuana Laws (1993-1995). I was also a faculty member for the Zinberg Center for Addiction Studies in Cambridge, Massachusetts (1993-1996). I am currently on several editorial boards, including the Harvard Health Letter (1990-present), the Journal of Social Pharmacology (1985-present), and Addiction Research (1991-present).

5. I have testified before the National Marijuana Commission and the Subcommittee of the Senate Small Business Committee in 1972, the House Select Committee on Narcotics in 1977, 1979 and 1989, the Controlled Substances Advisory Committee, and the Drug Abuse Advisory Committee in 1978, the Senate Judiciary Committee in 1980, and the House Judiciary Committee, Sub-Committee on Crime in 1997. I am also a frequent presenter at national and international conferences.

6. I have authored and co-authored some 170 articles in scholarly and professional journals, most of which deal with clinical comparisons of drug therapies. I have contributed chapters to medical textbooks, research publications, clinical protocols and conference reports. My work has been published in the *Journal of Clinical Endocrinology and Metabolism, New England*

Journal of Medicine, Journal of the National Cancer Institute, Mental Patients in Transition, Science Digest, Archives of General Psychiatry, Comprehensive Psychiatry, Clinical Medicine, Journal of Psychiatric Research, Psychosomatic Medicine, Diseases of the Nervous System, American Journal of Psychiatry, Scientific America, Psychopharmacologica, International Journal of Psychiatry, Encyclopedia of Science and Technology, International Narcotic Report, New York Law Journal, Journal of Consulting and Clinical Psychology, Drug Therapy, World Journal of Psychosynthesis, Medical Tribune, Contemporary Drug Problems, Social Science and Medicine, Villanova Law Review, Congressional Digest, Biological Psychiatry, The Sciences, Journal of Ethnopharmacology, Handbook on Drug Abuse, The Hastings Center Report, Harvard Mental Health Letter, Harper's, Nova Law Review, New Harvard Guide to Psychiatry, Journal of State Government, Cancer Treatment & Marijuana Therapy, Journal of Drug Issues, North Carolina Journal of International Law & Commercial Regulation, Encyclopedia of Human Biology, Drugs, Society and Behavior, Journal of American Medical Association, University of West Los Angeles Law Review, and *Journal of Psychoactive Drugs.*

7. I have authored and co-authored 12 books, several of which deal with the history and medical use of cannabis. These books include *Marijuana Reconsidered* (Harvard University Press, 2d ed. 1977), *Psychedelic Drugs Reconsidered* (Basic Books, 2d ed. 1981), *Psychedelic Reflections* (Human Sciences Press, 1982), *The Long Darkness: Psychological and Moral Perspectives on Nuclear Winter* (Yale University Press, 1986), and *Marijuana, the Forbidden Medicine* (Yale University Press, Revised Edition, 1997).

8. Based on my research, I have found that cannabis is remarkably safe. Although not harmless, it is surely

less toxic than most of the conventional medicines it could replace if it were legally available. Despite its use by millions of people over thousands of years, cannabis has never caused an overdose death. The most serious concern is respiratory damage from smoking, but that can easily be addressed by increasing the potency of cannabis and by making use of the technology to separate the particulate matter in marijuana smoke from its active ingredients, the cannabinoids (through devices known as vaporizers). Once cannabis regains the place in the U.S. Pharmacopoeia that it lost in 1941 after the passage of the Marihuana Tax Act (1937), it will be among the least toxic substances in that compendium. Right now the greatest danger in using cannabis medically is the illegality that imposes a great deal of anxiety and expense on people who are already suffering.

9. I have done extensive research on the history of the use of cannabis for medical purposes, as well as its legal regulation in the United States. The marijuana, cannabis, or hemp plant is one of the oldest psychoactive plants known to humanity. A native plant of central Asia, cannabis may have been cultivated as much as ten thousand years ago. It was certainly cultivated in China by 4000 B.C. and in Turkestan by 3000 B.C. It has long been used as a medicine in India, China, the Middle East, Southeast Asia, South Africa, and South America. The first evidence of the medical use of cannabis was published during the reign of the Chinese Emperor Chen Nun five thousand years ago. Cannabis was recommended for, among other things, malaria and rheumatic pains. Another Chinese herbalist recommended a mixture of hemp, resin, and wine as an analgesic during surgery. Hemp was also noted as a remedy by Galen and other physicians of the classical and Hellenistic eras, and it was highly valued in Europe.

10. Between 1840 and 1900, more than one hundred papers on the therapeutic uses of cannabis were published in American and European medical journals. It was recommended as an appetite stimulant, muscle relaxant, analgesic, sedative, anticonvulsant, and as a treatment for opium addiction. A professor at the Medical College of Calcutta, W.B. O'Shaughnessy, was the first Western physician to observe the use of cannabis as a medicine. He gave cannabis to animals, satisfied himself that it was safe, and began to use it with patients suffering from rabies, rheumatism, epilepsy, and tetanus. In a report published in 1839, he wrote that he found tincture of hemp (a solution of cannabis in alcohol, taken orally) to be an effective analgesic. He was also impressed with its muscle relaxant properties and called it "an anticonvulsive remedy of the greatest value." In 1890, J.R. Reynolds, a British physician, summarized thirty years of experience with *Cannabis indica,* finding it valuable in the treatment of various forms of neuralgia, including the tic douloureux (a painful facial neurological disorder), and added that it was useful in preventing migraine attacks. He also found it useful for certain kinds of epilepsy, for depression, and sometimes for asthma and dysmenorrhea.

11. The medical use of cannabis was in decline by 1890. It was believed that the potency of cannabis preparations was too variable, and that individual responses to orally ingested cannabis seemed erratic and unpredictable. Another reason for the neglect of research on the analgesic properties of cannabis was the generally increased use of opiates after the invention of the hypodermic syringe in the 1850s allowed soluble drugs to be injected for fast pain relief; hemp products are insoluble in water and so cannot easily be administered by injection. Toward the end of the nineteenth century, the development of such synthetic drugs as

aspirin, chloral hydrate, and barbiturates, also contributed to the decline of cannabis as a medicine. But these new drugs had, and still have today, striking disadvantages. More than a thousand people die from aspirin-induced bleeding each year in the United States, and barbiturates are, of course, far more dangerous.

12. Cannabis use in the United States was not particularly a matter of state or federal regulation until 1915, when California, prohibited marijuana possession or sale. In 1930, the year in which the Federal Bureau of Narcotics was founded, only sixteen states had laws prohibiting the use of cannabis. Sociologists have speculated that pressure from the liquor lobby figured among the more subtle factors in this sudden legal onslaught. More important, lack of scientific understanding concerning the effects of cannabis enabled the unsubstantiated statements of the Federal Bureau of Narcotics to go substantially unchallenged. The Marijuana Tax Act of 1937 was the culmination of a series of efforts on the part of the Federal Bureau of Narcotics to generate anti-marijuana legislation.

13. One might have expected physicians looking for better analgesics and hypnotics to turn to cannabinoid substances, but the Marijuana Tax Act of 1937 undermined any such experimentation. The Marijuana Tax Act of 1937 imposed a transfer tax upon certain dealings with marijuana. The Marijuana Tax Act of 1937 provided that anyone who imports, manufactures, produces, compounds, sells, deals in, dispenses, prescribes, administers, or gives away marijuana was required to register, record transactions and pay special taxes depending on the defined purposes. Those who failed to comply were subject to large fines or prison for tax evasion. Although it was ostensibly designed to prevent non-medical use of cannabis, the Marijuana Tax Act of 1937 made cannabis so difficult to obtain,

that cannabis was removed from the United States Pharmacopoeia and National Formulary in 1941. The Boggs Act of 1951 established mandatory prison terms and large fines for violation of any federal drug law, and the Narcotic Control Act of 1956 strengthened those penalties.

14. In the 1960's however, the public began to rediscover the medical value of cannabis, as letters appeared in lay publications from people who had learned that it could relieve their asthma, nausea, muscle spasms, or pain and wanted to share that knowledge with readers who were familiar with the drug. Meanwhile, legislative concern about recreational use of cannabis increased, and in 1970 Congress passed the Comprehensive Drug Abuse Prevention and Control Act (also called the Controlled Substances Act), which assigned psychoactive drugs to five schedules and placed cannabis in Schedule I, the most restrictive.

15. A few patients have been able to obtain medical cannabis legally in the past twenty years. Beginning in the 1970s, thirty-five states passed legislation that would have permitted medical use of cannabis but for the federal law. Several of those states actually established special research programs, with the permission of the federal government, under which patients who were receiving cancer chemotherapy would be allowed to use cannabis. These projects demonstrated the value of both smoked marijuana and oral THC (tetrahydrocannabinol). The FDA approved oral THC (Marinol) as a prescriptive medicine in 1986. In 1976, the federal government introduced the Individual Treatment Investigational New Drug Program (commonly referred to as the Compassionate IND), which provided cannabis to a few patients whose doctors were willing to undergo the paperwork-burdened and time-consuming application process. About three-dozen

patients eventually received cannabis before the program was discontinued in 1992, and six survivors are still receiving it – the only persons in the country for whom it is not a forbidden medicine.

16. The most effective spur to the movement for medical marijuana came from the discovery that it could prevent the AIDS wasting syndrome. It is not surprising that the Physicians Association for AIDS Care was one of the medical organizations that endorsed the California initiative prohibiting criminal prosecution of medical marijuana users.

17. I have conducted an extensive review of the literature concerning medical uses of cannabis and I am familiar with studies on the topic. Review of medical literature is a commonly used research tool. I have also studied clinically many patients who have used cannabis for the relief of a variety of symptoms; this clinical experience forms the basis of my book, *Marihuana, The Forbidden Medicine*. In my book I provide first-person accounts of the ways that cannabis alleviates symptoms of cancer chemotherapy, multiple sclerosis, osteoarthritis, glaucoma, AIDS and depression, as well as symptoms of less common disorders such as Crohn's disease, diabetic gastroparesis, and post-traumatic stress disorder. The patient narratives illustrate not only cannabis's therapeutic properties but also the unnecessary further pain and anxiety imposed on sick people who must obtain cannabis illegally.

18. Cannabis has several uses in the treatment of cancer. As an appetite stimulant, it can help to slow weight loss in cancer patients. It may also act as a mood elevator. But the most common use is the prevention of nausea and vomiting associated with cancer chemotherapy. About half of patients treated with anticancer drugs suffer from severe nausea and vomiting, which

are not only unpleasant and painful but a threat to the effectiveness of the therapy. Retching can cause tears of the esophagus and rib fractures, prevent adequate nutrition, and lead to fluid loss. Some patients find the nausea so intolerable they say they would rather die than go on. The antiemetics most commonly used in chemotherapy are metoclopramide (Reglan), the relatively new ondansetron (Zofran), and the newer granisetron (Kytril). Unfortunately, for many cancer patients these conventional antiemetics do not work at all or provide little relief.

19. The suggestion that cannabis might be used in the treatment of cancer arose in the early 1970s when some young patients receiving cancer chemotherapy found that marijuana smoking reduced their nausea and vomiting. In one study of 56 patients who got no relief from standard antiemetic agents, 78% became symptom-free when they smoked marijuana[1]. Oral tetrahydrocannibinol (THC) has proved effective where the standard drugs were not,[2] but smoking generates faster and more predictable relief because it raises THC concentration in the blood more rapidly to the needed level. Also, it may be hard for a nauseated patient to take oral medicine. In fact, there is strong evidence that most patients suffering from nausea and vomiting prefer smoked marijuana to oral THC.

20. Oncologists may have been ahead of other physicians in recognizing the therapeutic potential of cannabis. In the spring of 1990, two investigators randomly

[1] Vinciguerra, V., et al. Inhalation Marijuana as an antiemetic for cancer chemotherapy. *New York State Journal of Medicine* 1988; 88:525-527.

[2] Sallan, S.E., et al. Antiemetic effect of delta-9-tetrahydrocannibinol in patients receiving cancer chemotherapy. *New England Journal of Medicine* 1975; 293:795-797.

selected more than 2,000 members of the American Society of Clinical Oncology and mailed them an anonymous questionnaire to learn their views on the use of cannabis in cancer chemotherapy. Almost half of them responded. Although the investigators acknowledged that this group was self-selected and there might be a response bias, their results provide a rough estimate of the views of specialists on the use of Marinol (dronabinol, oral synthetic THC), and smoked marijuana. Only 43% said the available legal antiemetic drugs (including Marinol) provided adequate relief to all or most of their patients, and only 46% said the side effects of these drugs were rarely a serious problem. Forty-four percent had recommended the illegal use of cannabis to at least one patient, and half would prescribe it to some patients if it were legal. On average, they considered smoked marijuana more effective than Marinol and roughly as safe.[3]

21. Cannabis is also useful in the treatment of glaucoma, the second leading cause of blindness in the United States. In this disease, fluid pressure within the eyeball increases until it damages the optic nerve. About a million Americans suffer from the form of glaucoma (open angle) treatable with cannabis. Glaucoma is treated chiefly with eyedrops containing betablockers such as timolol (Timoptic), which inhibits the activity of epinephrine (adrenaline). They are effective but may have serious side effects such as inducing depression, aggravating asthma, slowing the heart rate, and increasing the risk of heart failure. Cannabis causes a dose-related, clinically significant drop in intraocular

[3] Doblin R. Kleiman M. Marihuana as anti-emetic medicine: a survey of oncologists' attitudes and experiences. *Journal of Clinical Oncology* 1991; 9:1275-80.

pressure that lasts several hours in both normal subjects and those with abnormally high ocular tension produced by glaucoma. Oral or intravenous THC has the same effect, which seems to be specific to cannabis derivatives rather than simply a result of sedation. Cannabis does not cure the disease, but it can retard the progressive loss of sight when conventional medication fails and surgery is too dangerous.[4]

22. About 15-20% of epileptic patients do not get much relief from conventional anticonvulsant medications. Cannabis has been explored as an alternative at least since 1975 when a case was reported in which marijuana smoking, together with the standard anticonvulsants phenobarbital and diphenylhydantoin, was apparently necessary to control seizure in a young epileptic man.[5] The cannabis derivative that is most promising as an anticonvulsant is cannabidiol. In one controlled study, cannabidiol in addition to the prescribed anticonvulsants produced improvement in seven patients with grand mal convulsions; three showed great improvement. Of eight patients who received a placebo instead, only one improved.[6] There are patients suffering from both grand mal and partial seizure disorders who find that smoked marijuana allows them to lower the doses of conventional anticonvulsant medications or to dispense with them altogether. Furthermore, anticonvulsants have many

[4] Hepler. R.S., et al. Ocular Effects of Marihuana Smoking. M.C. Braude, S. Szara (eds.). *The Pharmacology of Marihuana*. New York: Raven Press, 1976.

[5] Consroe, Paul F., et al. Anticonvulsant nature of Marihuana smoking. *Journal of the American Medical Association* 1975; 234-306-307.

[6] Cunha, J.M., et al. Chronic administration of cannabidiol to healthy volunteers and epileptic patients. *Pharmacology* 1980; 21:175-185.

potentially serious side affects, including bone softening, anemia, swelling of the gums, double vision, hair loss, headaches, nausea, decreased libido, impotence, depression and psychosis. Overdoses or idiosyncratic reactions may lead to loss of motor coordination, coma or even death.

23. There are many case reports of cannabis smokers using the drug to reduce pain: post-surgery pain, headache, migraine, menstrual cramps, and so on. Ironically, the best alternative analgesics are the potentially addictive and lethal opioids. In particular, cannabis is becoming increasingly recognized as the most effective treatment for the pain that accompanies muscle spasm, which is often chronic and debilitating, especially in paraplegics, quadriplegics, or other victims of traumatic nerve injury, and people suffering from multiple sclerosis or cerebral palsy. Many of them have discovered that cannabis not only allows them to avoid the risks of other drugs, but also reduces muscle spasms and tremors; sometimes they are even able to leave their wheel chairs.[7]

24. One of the most common causes of chronic pain is osteoarthritis, which is usually treated with synthetic analgesics. The most widely used of these drugs – aspirin, acetaminophen (Tylenol), and nonsteroidal anti-inflammatory drugs (NSAIDs) like ibuprofen and naproxen – are not addictive, but they are insufficiently powerful. Furthermore, they have serious side effects. Stomach bleeding and ulcer induced by aspirin and NSAIDs are the most common serious adverse drug reactions reported in the United States, causing an estimated 7,000 deaths each year. Acetaminophen

[7] Petro, D.J. Ellenberger, C., Treatment of human spacticity with delta-9-tetrahyrdrocannabinol. *Journal of Clinical Pharmacology* 1981; 21:413-416.

can cause liver damage or kidney failure when used regularly for long periods of time; a recent study suggests its chronic use may account for 10% of all cases of end-stage renal disease, a condition that requires dialysis or a kidney transplant.[8] Cannabis, as I pointed out earlier, has never been shown to cause death or serious illness. The University of Iowa conducted a study of cannabis for the relief of pain. Researchers gave oral THC or placebo at random to hospitalized cancer patients who were in severe pain. The THC relieved pain for several hours in doses as low as 5-10 mg, and for even longer at 20 mg. At this dose and in this setting, THC proved to be a sedative as well. It had fewer side effects than other commonly used analgesics.[9]

25. Oncologists are legally permitted to administer the synthetic THC (Marinol) orally in capsule form. But inhaled cannabis may be necessary for several reasons. For one thing, oral THC is subject to the variances of bioavailability. This means that two patients who take the same amount may also absorb different proportions of the dose, and a given patient may respond differently on different days, depending on the condition of the intestinal tract and other factors. Furthermore, the effects of smoked cannabis are perceived almost immediately, so patients can smoke slowly and take only what they need for a therapeutic effect. Patients who swallow Marinol may discover after an hour or so that they have taken too much for

[8] Perneger, T.V., Whelton, P., Klag, M.J. Risk of kidney failure associated with the use of acetaminophen, aspirin, and nonsteroidal anti-inflammatory drugs. *New England Journal of Medicine* 1994; 331:25:1675-1679.

[9] R. Noyes, S.F. Brunk, D.A. Baram, and A. canter, "Analgesic Effects of Delta-9-tetrahydrocannabinol, "*Journal of Clinical Pharmacology* 15 (February-March 1975): 139-143.

comfort or not enough to relieve their symptoms. In any case, a patient who is severely nauseated and constantly vomiting may find it almost impossible to keep the capsule down. Furthermore, Marinol makes some patients anxious and uncomfortable.

26. In theory, all the therapeutic properties of cannabis could be used if individual cannabinoids in addition to THC were isolated and made available separately as medicines. But this would be an enormously complicated procedure. Research sponsors would have to determine the therapeutic potential and evaluate the safety of sixty or more substances, synthesize each one found to be useful, and package it as a pill or aerosol. As some of these substances probably act synergistically, it would also be necessary to look at various combinations of them. However, no drug company would provide the resources needed for such a project because cannabis cannot be patented. It is a plant material containing many chemicals rather than a single one and no drug in the present pharmacopoeia is delivered by smoking.

27. About 500,000 have died of AIDS. Nearly 900,000 are infected with HIV, and about 400,000 have AIDS. Although the spread of AIDS has slowed down among homosexual men, the reservoir is so huge that the number of cases is sure to grow. Women and children as well as both heterosexual and homosexual men are now being affected; the disease is spreading most rapidly among intravenous drug abusers and their sexual partners. The disease can be attacked with anti-viral drugs, of which the best known are zidovudine (AZT) and protease inhibitors. Unfortunately, these drugs sometimes cause severe nausea that heightens the danger of semi-starvation for patients who are already suffering from nausea and losing weight because of the illness – a condition sometimes called the AIDS wasting syndrome. Cannabis is particularly useful for

patients who suffer from AIDS because it not only relieves the nausea but also retards weight loss by enhancing appetite. In one study the body weight and caloric intake of twenty-seven marijuana users and ten control subjects were compared for twenty-one days on a hospital research ward. The marijuana smokers ate more than the controls and gained weight; the controls did not. When they stopped smoking marijuana, they immediately started to eat less.[10] When it helps patients regain lost weight, it can prolong life. Although Marinol has been shown to relieve nausea and retard or reverse weight loss in patients with HIV infection, most patients prefer smoked cannabis. Cannabis is more effective and has fewer unpleasant side effects, and the dosage is easier to adjust. Many patients report that cannabis provides an appetite and pain relief without the semi-comatose effect of narcotics.

28. Opponents of medical cannabis often object that the evidence of its usefulness, although strong, comes only from case reports and clinical experience. It is true that there are, as yet, few double-blind controlled studies meeting the standards of the Food and Drug Administration, chiefly because legal, bureaucratic, and financial obstacles have been constantly put in the way. However we know more about cannabis than about most prescription drugs. Furthermore, individual therapeutic responses are often obscured in group experiments, and case reports and clinical experience are the source of much of our knowledge of drugs. As Dr. Louis Lasagna has pointed out, controlled experiments were not needed to recognize the therapeutic

[10] I. Greenberg, J. Kuelmle, J.H. Mendelson, and J.G. Bernstein, "Effects of Marijuana Use of Body Weight and Caloric Intake in Humans," *Journal of Psychopharmacology* (Berlin) 49 (1976): 79-84.

potential of chloral hydrate, barbiturates, aspirin, insulin or penicillin.[11] Nor was that the way we learned about the use or propranolol for hypertension, diazepam for status epilepticus and imipramine for enuresis; these drugs had originally been approved for other purposes.

29. In the experimental method known as the single patient randomized trial, active and placebo treatments are administered randomly in alteration or succession. The method is often used when large-scale controlled studies are inappropriate because the disorder is rare, the patient is atypical or the response to treatment is idiosyncratic.[12] Several patients have told me that they assured themselves of cannabis's effectiveness by carrying out such experiments on themselves, alternating periods of cannabis use with periods of abstention. I am convinced that the medical reputation of cannabis is derived partly from similar "experiments" conducted by many other patients.

30. Some physicians may regard it as irresponsible to advocate use of a medicine on the basis of case reports, which are sometimes disparaged as merely "anecdotal" evidence which counts apparent successes and ignores apparent failures. This would be a serious problem if cannabis were a dangerous drug. The years of effort devoted to showing that cannabis is exceedingly dangerous have proved the opposite. It is safer,

[11] Lasagna, L. Clinical trials in the natural environment. C. Stiechele, W. Abshagan, J. KichWeser (cds). *In Drugs Between Research and Regulations.* New York: Springer-Verlag, 1985:45-49.

[12] Larson, E.B. N-og-1 clinical trials: A technique for improving medical therapeutics. *Western Journal of Medicine* 1990; 152:52-56; Guyatt, G.H. Keller, J.L., Jaschke, R., et al. The N-of-1 randomized controlled trial: Clinical usefulness. *Annals of Internal Medicine* 1990; 112:293-299.

with fewer serious side effects, than most prescription medicines, and far less addictive or subject to abuse than many drugs now used as muscle relaxants, hypnotics and analgesics.

31. Based on the best available medical information, it is evident that cannabis should be made available even if only a few patients could get relief from it, because the risks are so small. For example, as I mentioned, many patients with multiple sclerosis find that cannabis reduces their muscle spasms and pain. A physician may not be sure that such a patient will get more relief from cannabis than from the standard drugs baclofen, dantrolene, and diazepam – all of which are potentially dangerous or addictive –but it is most certain that a serious toxic reaction to cannabis will not occur. Therefore the potential benefit is much greater than any potential risk.

32. During the past few years, the medical use of cannabis have become increasingly clear to many physicians and patients, and the number of people with direct experience of these uses has been growing. Therefore, the discussion is now turning from whether cannabis is an effective medicine to how it should be made available.

33. The government's position that cannabis has no accepted medical use is not rational, given the wealth of information confirming that cannabis is an effective medicine. Moreover, in my view, the government has long obstructed efforts to conduct research concerning cannabis. Had the United States government not stood in the way of such research, I believe that we would be at least 50 years ahead of where we are today in making cannabis available to persons who need it for medical reasons.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 8th day of October, 2004, at Wellesley, Massachusetts 02181.

/s/ Lester Grinspoon
LESTER GRINSPOON, MD